DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	HIV/AIDS Case Managers Managed Care Plans	**Memorandum No: 05-47 MAA** **Issued:** June 30, 2005
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration (MAA)	**For Information Call:** (800) 562-6188

Subject: HIV/AIDS Case Management: Fee Schedule Changes

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement a legislatively appropriated one (1.0) percent vendor rate increase for HIV/AIDS Case Management.

Maximum Allowable Fees

The 2005 Washington State Legislature appropriated a vendor rate increase of one (1.0) percent for the 2006 state fiscal year. The maximum allowable fees have been adjusted to reflect these changes.

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4^{th} or 5^{th} digits when applicable) or the entire claim will be denied.

Billing Instructions Replacement Pages

Attached are updated replacement pages D.3-D.6 for MAA's current *HIV/AIDS Case Management Billing Instructions*.

Bill MAA your usual and customary charge.

MAA's Provider Issuances

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

What records must be kept?

Specific to the Title XIX HIV/AIDS Case Management program

Please refer to the Department of Health's Case Management: A Guide for Assisting Persons Living with HIV/AIDS for required documentation specific to the Title XIX HIV/AIDS Case Management Program.

General to all providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, *for at least six years from the date of service* or more if required by federal or state law or regulation.

Fee Schedule

Use the following procedure codes with the appropriate modifiers when billing for Title XIX HIV/AIDS case management services:

Procedure Code/ Modifier	HCPCS Description	Maximum Allowable Effective 7/1/05
T2022-U8 **Limited to diagnosis** **042 or V08**	**Case management, per month. [Full Month]** A full-month rate applies when: A. The criteria in WAC 388-539-0300 have been met; and B. An individual service plan (ISP) has been in place 20 days or more in that month.	**$173.72**
T2022-U9 **Limited to diagnosis** **042 or V08**	**Case management, per month. [Partial Month]** A partial month rate applies when: A. The criteria is WAC 388-539-0300 have been met; and B. An ISP has been in place fewer than 20 days in that month.	**$86.86**

☞ **Note:** MAA reimburses full or partial month fees during monitoring per WAC 388-539-0350. See page C2 for a complete description of these services.

Procedure Code	HCPCS Description	Maximum Allowable Effective 7/1/05
T1023 **Limited to diagnosis** **042 or V08**	**Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.** **(Use this code for the comprehensive assessment)** This service must meet the requirements of WAC-539-0300 (1) and (5) and is reimbursed only ***once*** unless the client's condition changes as follows: A. There is a 50% change in need from the initial assessment; or B. The client transfers to a new case management provider. A comprehensive assessment is reimbursed in addition to a monthly charge (either full or partial) if the assessment is completed during the month a client is Medicaid eligible and ongoing case management has been provided.	**$139.12**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Use blue or black ink only! Do not use any other colored ink when making notations on claims. Also, do not use highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. Colored ink and/or highlighters will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.